
## REFERRAL FOR SERVICES

Please complete this form with as much detail as possible. This will enable ***secca*** to process the referral expeditiously and provide an individually tailored service.

## CLIENT DATA

**Part One:**

1. **Name of Client:**_____
   (Last Name) (First Name)
2. **Gender:** ☐ Male ☐ Female
3. **D.O.B.**_____**Age:**_____
4. **Address of Client:**_____

   _____**Post Code:**_____
5. **Contact Phone Number:**_____**Mobile:**_____
6. **If the client is over 18 years old, do they have a Legal Guardian appointed by the State Administrative Tribunal?** ☐ YES ☐ NO

6a. **Name & Contact Number of Legally Appointed Guardian:**_____

_____

7. **Is the client a Ward of the State?** ☐ YES ☐ NO

7a. **Has the client's Legal Guardian approved this referral?** ☐ YES ☐ NO

8. **Usual Living Arrangements:**
   ☐ Lives Alone
   ☐ Lives with Family member/Spouse
   ☐ Lives with others

9. **Accommodation Type.** (usual means 4 or more days per week, tick ONE box which best describes the situation) (including Foster Care)
   ☐ Other Community (eg: Friends, co-resident)
   ☐ Group Home/Duplex
   ☐ Small disability hostel (less than 20 people)
   ☐ Large disability hostel (more than 20 people)
   ☐ Hospital
   ☐ Nursing Home
   ☐ Other_____

**10. Approximate Length of time in this accommodation:**_____

**11. Type of Disability:**_____

**12. Please specify any special conditions because of the disability: (eg:** hearing, visual, mobility, feeding, concentration, toileting)

_____

**13. Are you registered with Disability Services Commission?**

If so, please circle which level **1 2 3**

**14. Are there any medical conditions you think we should know about?**

_____

_____

_____

**15. Medication Profile:** (please list any medications currently being prescribed dosage and reason for use)

| Name of Medication | Dosage | Reason |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**16. Main method of communication:** (Effective means client must be able to communicate more than just basic needs to unfamiliar people using the method)

☐ Little or NO EFFECTIVE communication

☐ Sign Language or other EFFECTIVE non-spoken communication

☐ Spoken language EFFECTIVE

**17. Main Language Spoken** (If living in a disability specific accommodation (eg: group home, hostel, etc) refer to the language spoken in the prior family home).

_____

**18. Type of Day Activity:** (Please tick **all** that apply)

***Education:***

Pre-primary/Kindergarten ☐
Mainstream School ☐
Education Support Unit ☐
Education Support Centre ☐
Education Support School ☐
TAFE ☐
University ☐

***Alternatives to Employment*** ☐
Recreation ☐
Rehabilitation ☐

***Home:***

Home duties ☐
Retired ☐

***Employment:***

Open Employment ☐
Supported Employment ☐
Sheltered Employment ☐

Length of time in employment
_____

Unemployed & seeking employment ☐
Seeking Day Placement ☐
Nor formal day activity ☐
Other
(Please specify)
_____

**19. Reason for Referral:** (Please be as detailed as possible)

**20. Has client attended education/counselling sessions previously?**(please specify)

_____

_____

_____

_____

**Part Two:**

## CLIENT'S PRIMARY SUPPORT PERSON/CARER DATA

1. **Name(s):**_____
2. **Address:**_____

   _____**Post code:**_____
3. **Contact Phone Number:**_____**Mobile:**_____
4. **Email Address:**_____
5. **Relationship to Client:**_____

**Part Three:**

**REFERRING PERSON'S DATA**

1. **Name:**_____
2. **Position:**_____
3. **Agency:**_____
4. **Contact Phone Numbers:**_____**Mobile:**_____
5. **Email Address:**_____
6. **Relationship to Client:**_____
7. **How did you learn about *secca*:** _____

**Part Four:**

**CONTACT PERSON TO ARRANGE APPOINTMENT**

1. **Name of person to contact:(regarding appointment)**_____
2. **Relationship to Client:**_____
3. **Address:**_____

   _____

   _____
4. **Contact Phone Numbers:**_____**Mobile:**_____
5. **Email Address:**_____
6. **Please note if there are any special times the person is available to be contacted:**

   _____
7. **Are there special times the person is available to be seen by a counsellor?**

   _____
8. **Will Client be attending *secca* independently?** ☐ **Yes** ☐ **No**
9. **If no, who will be accompanying Client?**_____
10. **If yes, which mode of transport will be used?**_____

**CONFIDENTIALITY STATEMENT**

***We will treat all information provided by you as confidential and will ensure all records provided to us are kept in a secure manner and available only to those persons authorised to have access to them.***

**Thank you for completing the Referral for Services. To enable processing,**

**Please post to** ***secca***
**City West Lotteries House**
**2 Delhi Street**
**West Perth WA 6005**

**Or Fax:** **(08) 9420 7229**

**Or E-mail:** **admin@secca.org.au**